

Advanced Emergency Medical Technician License Reinstatement Application



Idaho Emergency Medical Services Bureau

Send completed form to Idaho EMS Bureau, PO Box 83720, Boise, ID 83720-0036 or Fax to 208-334-4015



Checklist: License Holder Signature Affiliating Agency Authorized Signature Continuing Education Record Signed
 Skills Verification Signed by Medical Director \$35.00 Reinstatement Fee or Direct Bill Agency _____

Name _____
Last Name
First Name
Middle Name/Initial

Idaho EMS License # _____ or Social Security # _____

Circle the highest level of education: GED High School Diploma College: 1 2 3 4 5 6 7 8 Gender F M

Home Phone # _____ Work Phone # _____ Cell Phone # _____

E-Mail Address _____

Mailing Address _____
Street
City
State
Zip
County

Affiliation:

Qualifying Agency of Affiliation _____ Agency License # _____

Agency Authorized Signature _____
Signature
Printed Name

Career status for qualifying agency: Volunteer True Compensated Career Full Time Part Time

List all agency or hospital affiliations or associations (Use additional form if necessary.)

Agency/Hospital _____ Volunteer True Compensated Career Full Time Part Time

I am also an Idaho licensed/certified health care provider as a(n) (circle all that apply): MD / DO / PA / RN / RT / other (please specify) _____

Have you been charged with or convicted of a felony that you have not previously disclosed to the EMS Bureau? Yes No

If yes please explain: _____

Has an EMS agency taken any adverse action against you that you have not previously disclosed to the EMS Bureau? Yes No

If yes, please explain: _____

(Separate sheets may be attached)

Have you ever applied for or held an EMS certificate or license in any other state? Yes No

Have you ever been denied or had revoked an EMS certificate or license in any other state? Yes No

If you answered yes to either question, complete an *Idaho EMS License Verification Request* form for each state in which you have ever applied for, been denied, had revoked or held an EMS certificate / license. (This form is available at www.idahoems.org under Provider Licensure Forms)

Signature:

I hereby affirm the information herein is true and correct, and that I meet all requirements for EMS licensure as established by the State of Idaho.

Signature of Candidate _____ Date signed _____

For Bureau Use Only

Received in Bureau

AEMT License Reinstatement Education Record for lapsed license with effective date after July 2011

Lapsed license effective & expiration dates: _____

Candidate Name: _____

Each license cycle, an AEMT must complete:

- A minimum of 54 hours of continuing education (CE) **PLUS 135 minutes (2.25 hours) for each month lapsed**
- AEMT Transition Course Completion is required for reinstatement. *These hours count toward total hours needed.*
- A minimum of four (4) venues (at least one (1) hour in each)
- A minimum of eleven (11) categories
 - o Pediatric Assessment and Management must be a minimum of six (6) hours
 - o EMS Systems and Operations must be a minimum of three (3) hours, which includes both Landing Zone Officer (LZO) and Extrication Awareness courses

		Venues									Total hours in each Category (add across)
		Structured classroom sessions	Refresher programs that revisit original curriculum and have an evaluation component	Nationally recognized courses	Regional and national conferences	Teaching topical material	Agency Medical Director approved self-study or directed study	Case reviews and grand rounds	Formal distance learning	Journal article review with an evaluation instrument	
Categories	Pediatric assessment and management (6 hrs required)										
	EMS systems and operations (3 hours required for LZO and Extrication Awareness)										
	o Must have a minimum of four (4) hours per category in at least nine (9) of the remaining categories										
	Anatomy and physiology										
	Medical terminology										
	Pathophysiology										
	Life span development										
	Public health										
	Pharmacology										
	Airway management										
	Assessment										
	Medical conditions										
	Shock and resuscitation										
Trauma											
Special patient populations											
TOTAL HOURS											

During this license cycle, I have completed and documented the following:

Extrication Awareness: EMS Bureau Learning Management System, or an EST Certificate **Yes** ___ **No** ___ **Date:** _____

Landing Zone Officer (LZO) training: Distributed learning, or Classroom **Yes** ___ **No** ___ **Date:** _____

I certify that the information I have provided within this document including any attached supplemental information is true, complete and correct. I further understand that failing to disclose information or falsification of information may be punishable by prosecution for perjury pursuant to Section 18-5401, Idaho Code. I understand that this submission may be audited and I may be expected to produce valid documentation supporting the information I have submitted. Violations of IDAPA 16.01.12.10, "Falsification of Applications or Reports" may result in an EMS license denial, refusal to renew, suspension, or revocation.

Candidate signature

Date

AEMT Skills Verification

Candidate Name: _____

As the Physician Medical Director for the above named EMS Agency, I attest that this license renewal candidate has demonstrated proficiency in the skills and knowledge necessary to provide safe and effective patient care at the AEMT license level and in the recognition and management of traumatic injuries and medical life threats or conditions for the pediatric, adult, geriatric and special needs populations. Furthermore, I attest to the competency of this candidate in all skills and interventions within the “floor” of the Idaho EMS Physician Commission Scope of Practice that includes:

- Advanced airway, ventilation, and oxygenation
- Cardiovascular and circulation
- Immobilization
- Medication administration
- Normal and complicated childbirth
- Patient care reporting documentation
- Safety and transport operations and
- Vascular access.

Is the scope of practice for this license renewal candidate restricted as a result of failure to meet or maintain proficiencies? Yes No

If yes, please provide details:

Signature of MD

Printed Name

Date

